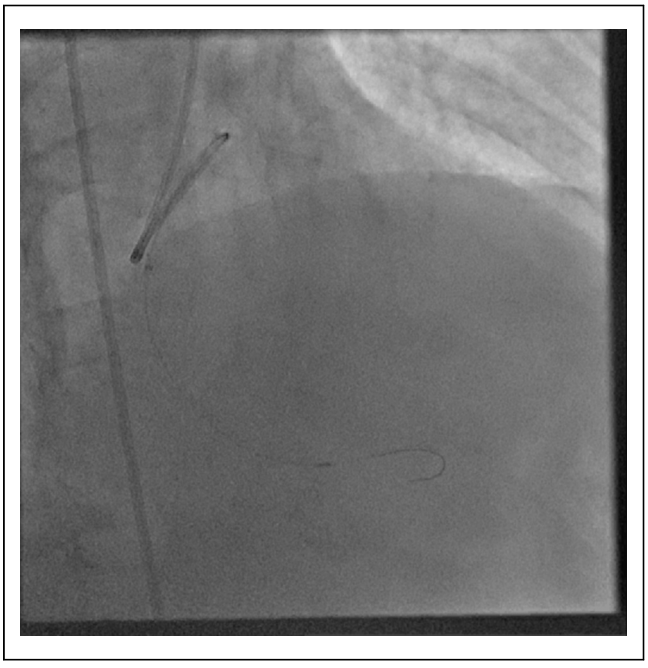
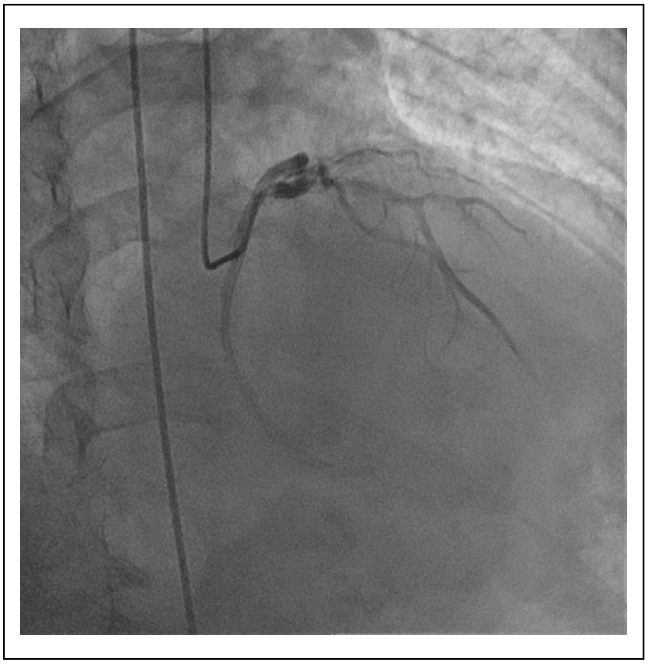
speed to 220000rpm and changed the guide wire to a Rota wire extra support and downsized a burr to 1.25mm, we could not ablate the lesion effectively. We judged the reason we could not ablate the lesion was the elasticity of the proximal part of LCx and chose to use mother-child catheter technique to control that. We advanced 5Fr sized child catheter Dio into LCx and performed rotablation through Dio. Then, we successfully attached the Rota burr to the lesion and ablated the lesion effectively. After successful rotablation, we could dilate the lesion by a balloon catheter easily and deployed a DES. Final angiogram showed good result.





Case Summary. We are sometimes faced to a situation that needs rotablation to the distal part of coronary artery. In this situation, we often cannot control a burr because of a bend and an elasticity of a proximal part of coronary artery. If we push a Rota burr excessively, there may be the risk that a Rota burr jump in and stuck to the lesion. In this case, we used mother-child catheter technique to overcome the problem. We can control the burr safely and effectively by using this method, but there are limitations of usable burr size and effective length of rotablation. The problem of effective length might be avoided by using guiding catheter extension device such as Guide Liner or Guidezilla.

TCTAP C-033

Left Main Lesion Treated with Two Stent Strategy, Complicated with Stent Dislodge, Successfully Solved by Homemade Snare Extraction

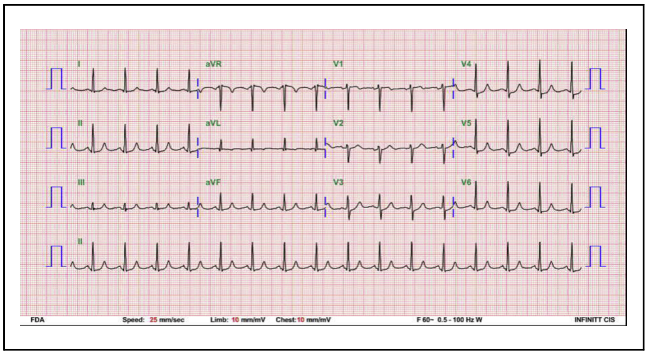
Mu-shiang Huang,[1] Shih-Hung Chan[2]
[1]National Cheng Kung University Hospital, Taiwan; [2]National Cheng Kung University Medical Center, Taiwan

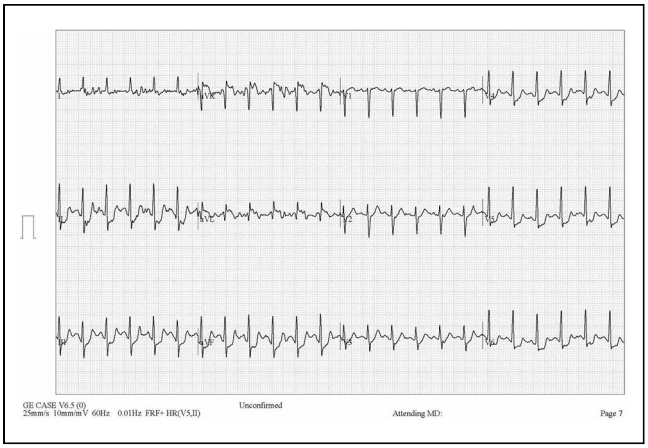
[CLINICAL INFORMATION]

Patient initials or identifier number. 16379632

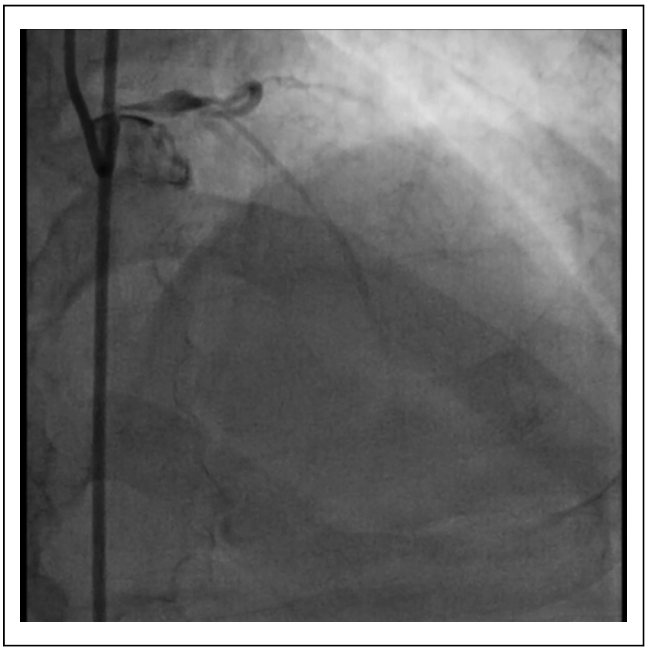
Relevant clinical history and physical exam. 63 years old male, nonsmoker
Past history: Hypertension, Diabetes mellitus, Dyslipidemia, chronic kidney disease (eGFR: 66 ml/min/m2)
Chief complaint: Intermittent chest tightness with increasing frequency for about one month
Physical examinations: no remarkable abnormality

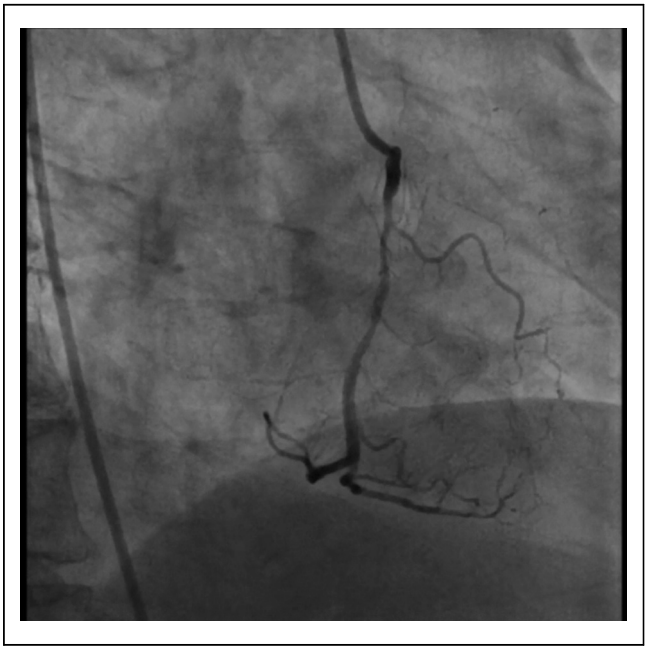
Relevant test results prior to catheterization. [Non-invasive test]
Treadmill exercise stress test: strong positive





Relevant catheterization findings. [Coronary angiography conclusion]
CAD/LM+3-V-D
LM.: 90% stenosis at orifice
LAD: 75% segmental stenosis at proximal and distal
LCX: 80% stenosis at proximal
RCA: 75% segmental stenosis at middle
Syntax score: 40, Euro-2 score: 0.73%
=>Coronary artery bypass grafting recommended, but patient refused
=>Percutaneous Coronary intervention decided instead



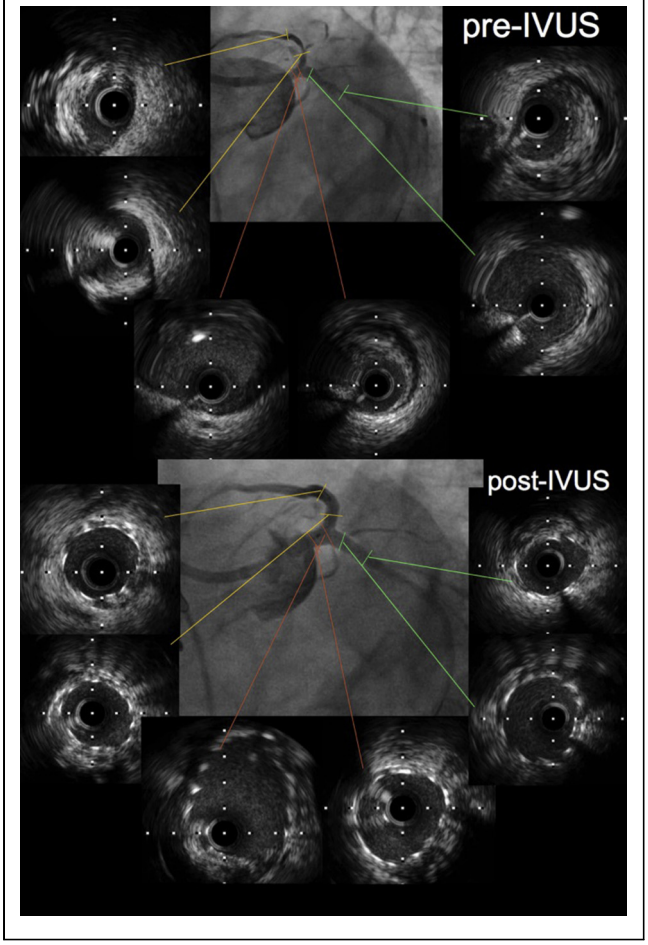


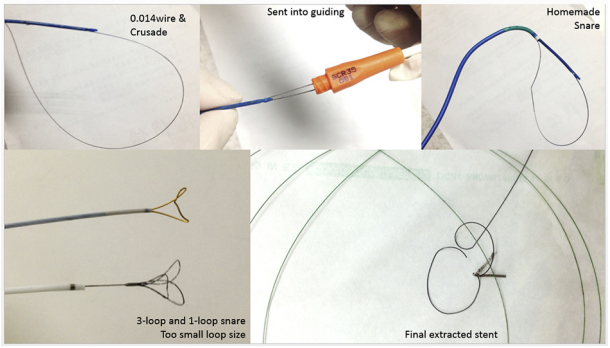
[INTERVENTIONAL MANAGEMENT]
Procedural step. [Strategy]

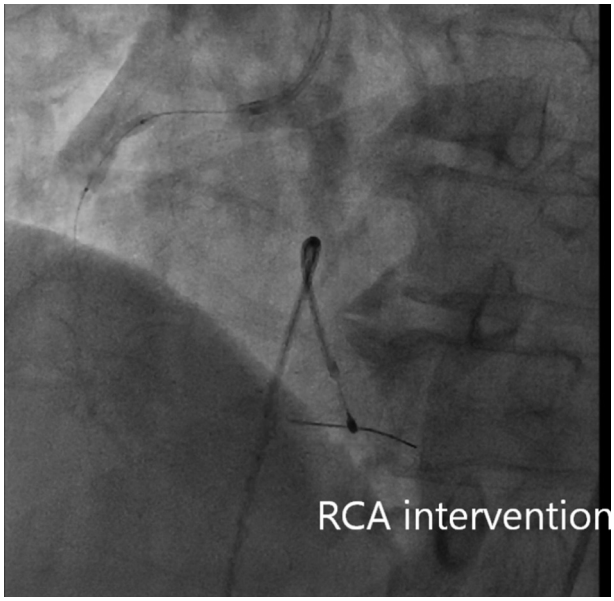
1. RCA intervention first, then do LCA intervention under Intra-aortic balloon pumping (IABP) and transvenous pacemaker(TVP) support
2. For LCA, IVUS guided PCI (To determine two or one stent strategy)

[RCA Intervention]
Guiding: SCR 3.5, Soft wire to distal, and Predilate with 3.0mm balloon, and deployed a 3.0mm BMS smoothly
[LCA intervention]
Guiding: EBU 3.5

1. 2.0mm balloon to predilate, then IVUS to evaluate lesions
2. IVUS conclusion: LM bifurcation lesion, medina (1,1,0), with proximal ~ distal LCX and LAD lesions
   Vessels size- LM: 3.5mm
   LAD: 3.0mm proximal, 2.5mm middle ~ distal
   LCX: 3.5mm proximal, 2.5 ~ 3.0mm distal
   => Decided Cullotte
3. dLAD: 2.5mm balloon to predilate and deployed 2.5mm DES
   dLCX: 2.5mm balloon to predilate and deployed 2.5mm BMS
4. LM ~ pLCX: 3.5mm balloon to predilate and deployed 3.5mm DES
5. LM ~ pLAD: rewire LAD, 3.0mm balloon to predilate. But when we try to deployed a 3.0mm/26mm stent, the stent dislodged. (The distal end of stent stuck in LM orifice with main body swirling in the aortic root)
6. 1-loop and 3-loop snare was tried but all failed, because of small loop comparing to huge aortic root
7. Customized a homemade snare composed of 0.014 wire, crusade microcatheter, and guiding catheter; the advantage of that is adjustable loop size and we finally catch the stent and pull out.
8. LM ~ pLAD: 3.0mm balloon predilate again and deployed a 3.0mm DES under Guideliner catheter support.
9. 4.0mm balloon to do proximal optimization of LM.







Case Summary. [PCI result]
CAD/LM+3-V-D s/p successful PCI with stenting for
LM with Cullotte technique (DES*2)
LAD (DES*1)
LCX (BMS*1)
RCA (BMS*1)
Procedure time: 5 hours, Total contrast: 200ml
=>Patient recovered well after procedure
[Conclusion]
Homemade snare composed of Crusade microcatheter,0.014 wire, and guiding catheter can be considered in stent dislodged situation, especially in our case, which need bigger loop size for stent dislodged in aortic root.
And IVUS guided PCI for LM lesion is essential.

TCTAP C-034

How to Manage Massive Thrombus in a RCA Long Stent In-Stent Restenosis Lesion via Trans-Radial Approach

Wei-Chun Huang,[1] Cheng Chung Hung[2]
[1]Kaohsiung Veterans General Hospital, Taiwan; [2]Kaohsiung Veteran General Hospital, Pingtung Branch, Taiwan

[CLINICAL INFORMATION]
Patient initials or identifier number. Mr. W

Relevant clinical history and physical exam. A 55-year-old man had received PTCA and stenting over RCA CTO lesion three years ago. This time he received CAG due to chest tightness, and RCA ISR lesion with massive thrombus was noted. We tried to remove all the thrombus and the final result was sub optimal. After medical therapy combined, the outcome was optimal.
55 Y/O male
Hyperlipidemia, smoker
Chest tightness for 1-2 months
Thallium-scan: partial defect in inferior wall (50-60% decrease to 30-40% decrease)

[INTERVENTIONAL MANAGEMENT]
Procedural step. The guild catheter was AL 1 short tip with ultimate bro3 wire under Finecross microcatheter support. The optimal medical therapy was also needed to get optimal result. The following angiography showed massive thrombus within RCA, and thrombus aspiration was done for several times, accompanying with anti-platelet agents. We used thrombuster for thrombus removal. The stent can't be advanced smoothly. The final result was suboptimal. After three months later, the following angiography showed better outcome.